



Summit Rehab

Patient Health Information

Name: _____

Please put a check in the box next to any medical conditions you may have, or have had in the past.

Musculoskeletal

- Osteoarthritis
- Rheumatoid arthritis
- Polymyalgia
- Lupus/SLE
- Fibromyalgia
- Chronic Fatigue
- Osteoporosis
- Headaches/Migraines
- Bulging Disks
- Leg Cramps
- Jaw pain/TMJ
- History of Falls
- Use cane, walker or crutches
- Other: _____

Circulation/Respiration

- Heart Condition
- Heart Attack
- Heart Arrhythmias
- Pace Maker
- High Cholesterol
- Blood Clots/Phlebitis
- Anemia
- Other: _____

Digestion

- Diabetes
- Kidney Problem
- Irritable bowel
- Bladder problem
- Liver problem
- Hernia
- Other: _____

Nervous System

- Stroke/TIA
- Parkinson's
- Multiple Sclerosis
- Epilepsy/Seizures
- Concussion/Brain injury
- Numbness or tingling
- Other: _____

Infectious Diseases

- TB
- Hepatitis
- Polio
- Other: _____

Skin

- Skin allergies/rashes
- Eczema/psoriasis
- Infectious skin diseases
- Shingles
- Other: _____

Please list any prior accidents, broken bones, or surgeries with approximate dates: _____

1. Have you had surgery for this injury? Yes ___ No ___ Surgery Date(s): _____

2. When did pain begin? (Date of Injury) _____

3. Have you had any Medical or Rehabilitative services for this injury/episode? Yes ___ No ___

4. Are you currently taking any prescription or non-prescription medications? If so please list them: _____

5. Do you Smoke? Yes ___ No ___ 6. Are you pregnant? Yes ___ No ___

7. List any other information that would assist us in your care: _____

8. Are you aware of what your diagnosis is? _____

9. Based upon your awareness, what are your expectations/goals while in Therapy? _____

Patient/Guardian Signature: _____ Date: _____

I have reviewed contraindications with _____ prior to initiating evaluation and treatment. The following contraindications were identified:

I have reviewed with _____ their rehabilitation potential prior to initiating treatment.

Therapist Signature: _____ Date: _____